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Supreme Court of the United States

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC., PACIFICARE OF CALIFORNIA, PACIFICARE HEALTH SYSTEMS FOUNDATION AND PACIFICARE HEALTH SYSTEMS, INC.,

Petitioners,

v.

LISA ELLEN SMITH,

Respondent.

On Petition For Writ Of Certiorari To The California Court Of Appeal, Second Appellate District, Division Three

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Are health care service plans "insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1012?

2. Assuming health care service plans constitute insurance under the McCarran-Ferguson Act, is California Health and Safety Code section 1363.1, which regulates arbitration provisions in health care service plan agreements, preempted by the Federal Arbitration Act, 9 U.S.C. § 2, or is it a law regulating the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. § 1012, and thus saved from preemption?

LIST OF PARTIES AND RULE 29.4(c) LIST

The parties to the proceeding below were the petitioners PacifiCare Behavioral Health of California, Inc., PacifiCare of California, PacifiCare Health Systems Foundation, PacifiCare Health Systems, Inc. and respondent Lisa Ellen Smith.

Petitioner PacifiCare Health Systems, Inc. wholly owns PacifiCare Health Plan Administrators, Inc. which is the sole member of petitioner PacifiCare Health Systems Foundation, a California non-profit corporation, and in turn wholly owns PacifiCare of California and petitioner PacifiCare Behavioral Health of California, Inc. PacifiCare Health Systems, Inc. is publicly held, and Capital Group International, Inc. is the only publicly held company that owns 10% or more of its stock.

Because the validity and constitutionality of California Health and Safety Code section 1363.1 has been drawn into question in this action, 28 U.S.C. § 2403(b) may be applicable and hence petitioners have served the Attorney General for the State of California with this petition. Neither any of the parties nor the lower courts have certified to the Attorney General for the State of California the fact that the constitutionality of Health and Safety Code section 1363.1 has been drawn into question by this litigation pursuant to 28 U.S.C. § 2403(b).

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PETITION FOR WRIT OF CERTIORARI

Petitioners PacifiCare Behavioral Health of California, Inc., PacifiCare of California, PacifiCare Health Systems Foundation and PacifiCare Health Systems, Inc., respectfully pray that a writ of certiorari issue to review the judgment and opinion of the California Court of Appeal, Second Appellate District, Division Three, entered in the above proceeding on October 25, 2001.

OPINIONS BELOW

The opinion of the California Court of Appeal is reported at 93 Cal. App. 4th 139, 113 Cal. Rptr.2d 140 and is reprinted in the Appendix hereto, pp. 1-35, *infra*.

The minute order of the Los Angeles County Superior Court denying the petition to compel arbitration that was affirmed by the Court of Appeal was not reported. It is reprinted in the Appendix hereto, pp. 36-37, *infra*.

The California Supreme Court's order denying review of the Court of Appeal's opinion was not reported. It is reprinted in the Appendix, p. 38, *infra*.

JURISDICTION

The opinion of the California Court of Appeal, Second Appellate District, Division Three, was entered on October 25, 2001. Petitioners timely filed a Petition for Review in the California Supreme Court on December 4, 2001. (Cal. Rules of Court, Rule 28(b).) On February 20, 2002, the California Supreme Court issued its order summarily denying the Petition for Review. (Appendix, p. 38.)

The jurisdiction of this Court to review the judgment of the California Court of Appeal, Second Appellate District, Division Three is invoked under 28 U.S.C. § 1257. As review of the Court of Appeal decision reveals, the Court squarely addressed the federal preemption and supremacy clause issues set forth in the questions presented for review. *Orr v. Orr*, 440 U.S. 268, 274-275, 99 S. Ct. 1102, 1109, 59 L. Ed. 2d 306 (1979) (state court's resolution of federal question demonstrates federal question properly raised in proceedings). Moreover, as required by Supreme Court Rules, Rule 14.1(h), the statement of the case, *infra*, specifies the stages in the proceedings, both in the court of first instance and the appellate court at which the federal questions sought to be reviewed were raised.

STATUTES INVOLVED

A. Article VI, Clause 2, United States Constitution.

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

B. California Health and Safety Code section 1363.1.[1]

C. 9 U.S.C. § 1.

D. 9 U.S.C. § 2.

E. 15 U.S.C. § 1012.

STATEMENT OF THE CASE

A. The Initial Proceedings.

On October 26, 1999, plaintiff Lisa Ellen Smith filed a complaint for damages against PacifiCare Behavioral Health of California, Inc., PacifiCare of California, PacifiCare Health Systems Foundation and PacifiCare Health Systems, Inc. The complaint asserted claims for breach of the implied covenant of good faith and fair dealing, negligence, negligent and intentional infliction of emotional distress, breach of contract and violations of California Business and Professions Code section 17200. The central allegation of the complaint was that Ms. Smith was entitled to receive mental health services from PacifiCare Behavioral Health of California, Inc., pursuant to an agreement between PacifiCare and the Southern California Schools Employee Benefits Association. The complaint alleged that Ms. Smith's father, Thomas Battle, was an

[1] Pursuant to Supreme Court Rule 14.1(f), because the following statutes are lengthy, they are set forth in the Appendix, pp. 39-42, *infra*.

employee of a public school and that plaintiff was dependent under the coverage provided to him under the Association's agreement with PacifiCare. According to the complaint, PacifiCare failed to provide Ms. Smith with necessary mental health care and as a result she suffered severe injuries.

On December 16, 1999, pursuant to the arbitration provision in the Agreement, the PacifiCare defendants filed a notice of petition and petition to compel arbitration and stay of action. On January 25, 2000, plaintiff filed a memorandum of points and authorities in opposition to the petition to compel arbitration. Plaintiff argued that enforcement of the arbitration provision was barred because it did not comply with the requirements of California Health and Safety Code section 1363.1 which placed restrictions on the manner in which arbitration agreements could be presented in a health care service plan contract. Plaintiff did not dispute that section 1363.1 would be preempted under the plain provisions of the Federal Arbitration Act ("FAA"). Rather, plaintiff argued that the FAA was essentially trumped by the McCarran-Ferguson Act, which saves state laws regulating insurance from federal preemption.

After hearing argument, on February 10, 2000, the court entered its order denying the petition.

B. The Appeal.

The PacifiCare defendants appealed, arguing that section 1363.1 was preempted by the FAA. After consolidating the appeal with a writ proceeding involving PacifiCare and an identical issue – *Rivera v. Superior Court*, B145004 – on October 25, 2001, Division Three of the

Second Appellate District issued a published decision affirming the order denying arbitration. Appendix, pp. 1-35. The Court held that section 1363.1 was a law regulating the business of insurance and hence saved from preemption by the FAA under the McCarran-Ferguson Act. (*Ibid.*)

On December 4, 2001, PacifiCare filed a Petition for Review in the California Supreme Court. Appendix, pp. 43-44. On February 20, 2002, the Supreme Court issued its order denying review. Appendix, p. 38.

WHY CERTIORARI IS WARRANTED

I. REVIEW IS NECESSARY IN ORDER TO RESOLVE THE CONFLICT AMONG THE FEDERAL AND STATE COURTS AS TO WHETHER HEALTH CARE SERVICE PLANS ARE "INSURANCE" WITHIN THE MEANING OF THE MCCARRAN-FERGUSON ACT.

In this case, the California Court of Appeal held that California Health and Safety Code section 1363.1, which regulates arbitration provisions in health care service plan agreements, was saved from preemption under the Federal Arbitration Act, 9 U.S.C. § 2, because it was a law regulating the "business of insurance" within section 1012(b) of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b). The Court of Appeal recognized that the question of whether section 1363.1 was saved from preemption under the McCarran-Ferguson Act involved a two-step inquiry. First, the court had to determine whether or not health care service plans constituted insurance under the McCarran-Ferguson Act. Second, even assuming such

plans fell within the definition of insurance under the McCarran-Ferguson Act, it was necessary to determine whether or not 1363.1 purported to regulate the insurance, as opposed to the non-insurance aspects, of such agreements.

With respect to the first inquiry, the court concluded that health care service plan service agreements are insurance within the meaning of the McCarran-Ferguson Act. This Court has never expressly addressed the question of whether health care service plans or such related entities as health maintenance organizations (HMOs) constitute insurance either under the McCarran-Ferguson Act or the savings clause of the Employee Retirement Income Security Act of 1974 (ERISA).[2]

There is currently a split of authority between the federal appellate courts, as well as between federal and state appellate courts, concerning the question of whether health care service plans and HMOs constitute insurance

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[2] In *Group Life and Health v. Royal Drug Co.*, 440 U.S. 205, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), the Court concluded that with respect to agreements between a health service plan and pharmacies to provide prescription drugs to enrollees, the health care service plan was not engaging in the business of insurance for purposes of the antitrust exemption of the McCarran-Ferguson Act. This was because those agreements did not involve the spread of risk or any other factor pertinent to evaluating whether insurance exists. 440 U.S. at 209, 213-214. The Court did not address the question of whether an agreement between a health care service plan and its members constituted insurance within the meaning of the McCarran-Ferguson Act. See 440 U.S. at 230, n.37.

under either the McCarran-Ferguson Act or the savings clause of ERISA.[3]

Numerous federal courts have held that health care service plans and HMOs do not constitute insurance under either ERISA or the McCarran-Ferguson Act. See, e.g., *O'Reilly v. Ceuleers*, 912 F.2d 1383 (11th Cir. 1990) [HMO not insurance company or in business of insurance for purposes of ERISA]; *Texas Pharmacy Association v. Prudential Ins. Co.*, 105 F.3d 1035, 1038 (5th Cir. 1997) [state law governing pharmaceutical coverage in health plans not saved by ERISA because HMOs and preferred provider organizations (PPOs) do not constitute insurance]; *Prudential Ins. Co. v. National Park Medical Center*, 154 F.3d 812, 829 (8th Cir. 1998) [state statute that regulated not simply health insurance, but HMOs, PPOs and health care service plans does not fall within ERISA savings clause because such entities do not constitute insurance]; *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 723, n.6 (2d Cir. 1993), reversed on other grounds, *New York Conference of Blue Cross v. Travelers Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995) [concluding that HMOs do not engage in the "business of insurance"]; *Pomeroy v. Johns Hopkins Medical Services, Inc.*, 868 F. Supp. 110, 114-115 (D. Md. 1994) [HMOs not in the "business of insurance" for purposes of ERISA savings clause]; *Dearmas v. AV-Med, Inc.*, 814 F. Supp. 1103, 1107-1108 (S.D. Fla. 1993) [HMO

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[3] As this Court has recognized, the definitions of "insurance" for purposes of ERISA's savings clause and the McCarran-Ferguson Act "serve the same federal policy and utilize the same language to define what is left to the States." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744, n.21, 105 S. Ct. 2380, 85 L. Ed. 2d 728 (1985).

is not insurance within the meaning of ERISA savings clause].

Consistent with this line of authority, state courts have similarly found that HMOs and other health care service plans do not constitute insurance. See *State of Florida v. State Mutual Life Assurance Co. of America*, 604 S.2d 505, 512 (Fla. D. Court App. 1992) [the McCarran-Ferguson Act "has nothing to do with the regulation of HMOs"]; *Hospital Service Corp. of Rhode Island v. Pennsylvania Ins. Co.*, 227 A.2d 105, 111 (R.I. 1979) [noting that HMOs and health care service plans do not fit within the definition of insurance]; *New Mexico Life Ins. Guarantee Association v. Moore*, 596 P.2d 260, 263 (N.M. 1979) [nonprofit corporation acting as a health care service plan by contracting with physicians to provide services to members does not fit within definition of insurance].

In contrast, as the Court of Appeal noted here, other federal appellate courts, most notably the Ninth Circuit in *Washington Physician's Services Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), have held that HMOs constitute insurance for purposes of the McCarran-Ferguson Act and the savings clause of ERISA. See also *Kentucky Association of Health Plans, Inc. v. Nichols*, 227 F.3d 352, 364 (6th Cir. 2000); *Corporate Health Ins., Inc. v. Texas Department of Insurance*, 215 F.3d 526, 538 (5th Cir. 2000).[4]

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[4] There appears to be a conflict between the Fifth Circuit's decision in *Texas Pharmacy Association v. Prudential Ins. Co. of America*, 105 F.3d 1035 holding that laws that regulate HMOs generally are not laws that regulate insurance, and the Court's subsequent holding in *Corporate Health Ins., Inc. v. Texas Department of Insurance*, 215 F.3d

(Continued on following page)

The differing results between the two lines of authority stems chiefly from the extent to which the courts analyze the difference between health care service plans and true insurance. Those which classify health care service plans as insurance focus solely on the question of whether, and not how, risk has been transferred. See, e.g., *Washington Physician's Services Association v. Gregoire*, 147 F.3d at 1045-1046. However, as this Court has held, insurance requires the assumption and allocation of risk as between the insurer and the policyholder. See *Securities and Exchange Commission v. Variable Annuity Ins. Co.*, 359 U.S. 65, 71-73, 79 S. Ct. 618, 621-623, 3 L. Ed. 2d 640 (1959). Yet, that is not the case with health care service plans. As the Eleventh Circuit recognized in *O'Reilly v. Ceuleers*, 912 F.2d 1383, under "this form of pre-paid health plan, the consumer pays a fixed periodic fee to a functionally integrated group of doctors in exchange for the group's agreement to provide any medical treatment that the subscriber might need. *The economic risk is thus borne by the doctors.*" 912 F.2d at 1389; emphasis added.

The PacifiCare plan by definition simply procures the agreement of third party physicians to provide care to members for a prearranged fee paid by the plan – any risk is shifted not from the patient to the plan, but from the patient to the physician. See Cal. Health & Saf. Code, § 1342(d) [noting that purpose of Knox-Keene Act includes "transferring the financial risk of health care from patients to providers"] and § 1345(i) ["'Provider' means any professional person, organization, health facility, or other person or institution licensed by state to deliver or furnish

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526 that HMOs may constitute insurance for purposes of the savings clause of ERISA.

health care services"]. It therefore does not fit within the definition of insurance for purposes of the McCarran-Ferguson Act or, for that matter, ERISA.

Health care service plans, including HMOs, PPOs and other related entities that are alternatives to traditional fee-for-service delivery of health care now serve the needs of an ever-growing portion of the population. It is therefore a crucial issue whether such service plans constitute insurance for purposes of the McCarran-Ferguson Act and other federal statutes, most specifically, ERISA, which carve out special exceptions for state laws regulating the business of insurance. As noted above, state and federal courts are divided on this important issue. It is therefore vital that this Court grant review in order to set down clear guidelines for future cases.

II. REVIEW IS WARRANTED IN ORDER TO CLARIFY THE STANDARDS FOR DETERMINING WHETHER A STATE LAW REGULATES INSURANCE UNDER THE MCCARRAN-FERGUSON ACT AND TO DEFINE THE STANDARDS GOVERNING STATE REGULATION OF ARBITRATION PROVISIONS IN HEALTH CARE SERVICE PLANS.

In furtherance of the important public policy of encouraging arbitration of disputes, Congress enacted the Federal Arbitration Act. 9 U.S.C. § 1, et seq. As this Court held in *Doctor's Associates, Inc. v. Casarotto*, 517 U.S. 681, 687, 116 S. Ct. 1652, 1656, 134 L. Ed. 2d 902 (1996), to achieve this goal, Congress decreed that state laws that impose special conditions on arbitration provisions are expressly preempted under the FAA.

Here, the Court of Appeal acknowledged that California Health and Safety Code section 1363.1 was precisely the sort of statute that falls within the plain language of the FAA preemption provision, since it imposes special requirements on arbitration provisions in health care service plan agreements. (Appendix, p. 17.) However, the Court of Appeal held that the FAA – as a law of general application – was trumped by the McCarran-Ferguson Act, in that California Health and Safety Code section 1363.1 was saved from preemption as a law regulating the business of insurance.

In so holding, the Court of Appeal relied upon a hodgepodge of federal appellate court decisions. Those decisions pull bits and pieces from this Court's jurisprudence interpreting the McCarran Act to weave together standards that are so general that essentially any state law concerning insurance companies, let alone entities dubiously classified as insurance, such as health care service plans, falls within the McCarran Act. For some courts, the touchstone is risk – any contract which in any way involves allocation of risk necessarily constitutes insurance under the McCarran Act. Other courts find that any state statute addressing any aspect of an insurance contract – even if unrelated to the ability of one party or the other to obtain benefits under the agreement – regulates the business of insurance under the McCarran Act.

It is necessary that this Court grant review in order to clarify the standards governing application of the McCarran-Ferguson Act. Terms such as "allocation of risk" or "integral to the policy relationship" lack precise meaning, and are applied by courts in an ad hoc manner to sanction virtually any state regulation of not simply insurance companies, but even non-insurance entities such as

petitioners. This need for clarity is especially vital with respect to state regulation of arbitration provisions, given *the Congressional mandate that* arbitration not be improperly subject to state regulation, and the widespread use of such provisions in insurance contracts and agreements involving health care service plans and other related entities such as health maintenance organizations.

The Court of Appeal opinion here reflects a growing trend of loose application of the McCarran-Ferguson Act, as well as state dissatisfaction with, and regulation of, arbitration provisions. It is therefore essential that this Court grant review.

A. The Three-Factor McCarran-Ferguson Test.

This Court has repeatedly applied a three-factor test in determining whether or not a state statute regulates the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq. The Court considers "'first, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.'" (*Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743, 105 S. Ct. 2380, 2391, 85 L. Ed. 2d 728 (1985); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-49 107 S. Ct. 1549, 1553, 95 L. Ed. 2d 39 (1987).

The Court has emphasized that a state regulation does not have to satisfy all three McCarran-Ferguson factors, none is "determinative in itself" and they are instead "checking points." (*UNUM Life Ins. Co. of America*

v. Ward, 526 U.S. 358, 360,119 S. Ct. 1380, 1383, 143 L. Ed. 2d 462 (1999); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 102 S. Ct. 3002, 3009, 73 L. Ed. 2d 647 (1982).

In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S. Ct. 3002, the Court applied the McCarran-Ferguson factors in concluding that a health insurer's use of a professional association's peer review committee to examine chiropractors' statements and charges did not constitute the business of insurance within the anti-trust exemption of the McCarran-Ferguson Act. With respect to the first McCarran factor – "whether the practice has the effect of transferring or spreading a policyholder's risk" – the Court concluded that the practice had no impact. 458 U.S. at 129-130, 102 S. Ct. at 3009. The Court noted that the peer review occurred only after the risk had already been transferred by means of execution of the policy between the insured and the insurer. 458 U.S. at 130, 102 S. Ct. at 3009. As the Court noted, the "challenged peer review arrangement is logically and temporally unconnected to the transfer of risk accomplished by ULL's insurance policies." (*Ibid.*)

This Court also concluded that the peer review practice did not meet the second McCarran factor in that it was not an "integral part of the policy relationship between insurer and insured." 458 U.S. at 131, 102 S. Ct. at 3010. First, the challenged arrangement was between the insurance company and a third party – the professional association that performed the peer review. Second, and critically, the Court noted that the peer review practice itself had no effect on the substantive rights and obligations as between the insurer and the insured. The mere fact that the peer review practice might directly involve

interpretation and enforcement of the insurance contract in that the peer review committee might make payment decisions based on provisions of the contract was irrelevant. As the Court emphasized:

> "[W]hen presented with policyholder claims for reimbursement, ULL must decide whether the claims are covered by its policies. But these decisions are entirely ULL's, and its use of NYSCA's Peer Review Committee as an aid in its decisionmaking process is a matter of indifference to the policyholder, whose only concern is *whether* his claim is paid, not *why* it is paid."

458 U.S. at 132, 102 S. Ct. at 3010, emphasis in original.

Finally, as to the third factor, the Court noted that the peer review practice was not limited to entities within the insurance industry – the third parties participating in the peer review committee were chiropractors, not insurers. 458 U.S. at 132-133, 102 S. Ct. at 3010.

In *United States Department of Treasury v. Fabe*, 508 U.S. 491, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993), the Court similarly applied the McCarran factors in concluding than an Ohio statute governing insurance company insolvency regulated the business of insurance and hence barred application of a federal bankruptcy statute that would have given the United States priority on its claims against the insolvent insurer. Noting that the Ohio statute protected policyholders by giving them priority in payment, the Court concluded that the statute satisfied the second McCarran factor in that it was integral to the relationship between the parties, making certain that "if possible, policyholders ultimately will receive payment on their claims." 508 U.S. at 506, 113 S. Ct. at 2211. That the

practice did not affect the allocation of risk as between the policyholder and the insured, and might affect creditors other than those in the insurance industry, was irrelevant in light of the statute's clear impact on the substantive rights as between the insurance company and its insureds. 508 U.S. at 505-506, 113 S. Ct. at 2211.

In *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, this Court applied the three McCarran factors in determining whether or not the California notice-prejudice rule regulated insurance within the meaning of the savings clause of the Employee Retirement Income Security Act of 1974 (ERISA). Under the notice-prejudice rule, the mere fact that an insured did not timely submit a claim to the insurance company did not necessarily foreclose an action for benefits under the policy – the insurer could prevail only to the extent it demonstrated that it was prejudiced by reason of the belated notice. 526 U.S. at 366-367, 119 S. Ct. at 1386. With respect to the first McCarran factor, the Court noted that the notice-prejudice rule did not appear to affect allocation of risk as between the parties. However, the Court found that the rule met the other two McCarran factors – it was directed solely to insurance contracts and, critically, was integral to the contractual relationship between the insurer and the insured – adding a contract term affecting the substantive ability of a party to enforce the agreement. 526 U.S. at 374-375, 119 S. Ct. at 1389-1390.

Citing *Fabe*, *supra*, 508 U.S. 491, the Court of Appeal suggests that the McCarran factors are only applied for purposes of determining whether a particular entity or practice falls within the antitrust exemption of the Act and not when determining whether a state statute regulates the business of insurance for purposes of preemption.

(Appendix, p. 31.) Yet, as noted above, review of *Fabe* utterly repudiates the Court of Appeal's suggestion – in *Fabe*, this Court *expressly applied* the three-factor McCarran test in the context of preemption analysis. Moreover, in interpreting the virtually identical provisions of the Employee Retirement Income Security Act of 1974 (ERISA) which "save" state laws regulating the business of insurance from preemption, the Court has, not surprisingly, applied the three-factor McCarran test. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 119 S. Ct. 1380, 143 L. Ed. 2d 462; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S. Ct. 1549, 95 L. Ed. 2d 39.

Application of the McCarran factors to Health and Safety Code section 1363.1 consistent with *Pireno*, *Fabe*, and *UNUM*, makes it clear that the provision does not regulate insurance. It has no impact on the allocation of risk as between the parties, is not integral to the policy relationship between the parties, nor is it limited to the insurance industry. Hence, section 1363.1 is preempted by the FAA.

B. Health And Safety Code Section 1363.1 Does Not Satisfy The McCarran Factors.

1. The Court of Appeal acknowledges that Health and Safety Code Section 1363.1 does not have the effect of transferring or spreading policyholder risk.

The first McCarran factor to be considered in determining whether a state statute regulates the business of insurance is whether the regulation itself has the effect of transferring or spreading policyholder risk. As the Court noted in *UNUM*, 526 U.S. at 374, 119 S. Ct. at 1389, a state statute regulates insurance under this test if it may be said to "'alter the allocation of risk for which the parties initially contracted.'" As the Court of Appeal acknowledged, section 1363.1 has nothing to do with allocation of risk as between the parties. (Appendix, p. 32.) Thus, it does not meet this McCarran Act standard.

2. An arbitration provision is not an integral part of the policy relationship between the insured and the insurer.

The next McCarran-Ferguson factor concerns whether the rule in question constitutes an "integral part of the policy relationship between the insurer and the insured." *Metropolitan Life Ins. Co.*, 471 U.S. at 743, 105 S. Ct. at 2391; *UNUM*, 526 U.S. at 374, 119 S. Ct. at 1389. As noted, in determining whether or not a state statute regulates something that is an integral part of the policy relationship between the insurer and insured, this Court has looked at the impact that the practice has on the substantive rights under the policy as between the insurer and insured. Thus, in *Pireno*, *Fabe* and *UNUM*, the key

factor was whether the state statute affected the ability of the insurer or the insured to obtain the full benefits of the agreement.

For example, in *Pireno*, the Court found that use of the peer review committee to aid the insurer in making a benefits determination was not a practice integral to the policy relationship between the insurer and insured. As the Court emphasized, the insured was interested in whether the claim was paid, not why it was or was not paid. 458 U.S. at 132, 102 S. Ct. at 3010. Similarly, in *Fabe*, the state insolvency law directly affected the substantive rights of the insured in that it promoted the goal of seeing that insureds were properly paid in accordance with the policy terms to the extent any funds were available to do so. 508 U.S. at 506, 2210 ["The Ohio statute is enacted 'for the purpose of regulating the business of insurance' to the extent that it serves to ensure that, if possible, policyholders ultimately will receive payment on their claims"].

Finally, in *UNUM*, the notice-prejudice rule was found to be an integral part of the policy relationship because it affected whether or not an insurance company would have a defense to paying a claim under the policy. 526 U.S. at 369, 119 S. Ct. at 1387 ["Insurance policies like UNUM's frame timely notice provisions as conditions precedent to be satisfied by the insured before an insurer's contractual obligation arises"]; see also 526 U.S. at 374, 119 S. Ct. at 1389-1390 ["California's rule changes the bargain between insurer and insured; it 'effectively creates a mandatory contract term' that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision"].

In contrast, arbitration provisions of the sort contained in the PacifiCare contract and purportedly subject to section 1363.1, in no way impact, much less impair, the ability of one party or the other to enforce the substantive terms of the policy. An arbitration agreement merely affects the forum for resolving disputes between the parties in accordance with the substantive terms of the policy – it does not alter the terms of the agreement or the relationship between the insurer and insured. Both are equal before the neutral arbitrator.

Indeed, the California Supreme Court has repeatedly held that the mere fact that a party must arbitrate a dispute, as opposed to seek redress in court, does not affect a party's substantive rights. Thus, in *Doyle v. Giuliucci*, 62 Cal.2d 606, 610, 401 P.2d 1 (1965), the Court rejected the contention that allowing a parent to waive a minor's right to seek redress in court and to instead arbitrate a dispute adversely impacted the minor's substantive rights. As the Court noted, "[t]he arbitration provision . . . does no more than specify a forum for the settlement of disputes." (*Ibid.*; see also *Madden v. Kaiser Foundation Hospitals*, 17 Cal.3d 699, 709, fn. 11, 552 P.2d 1178 (1976) [rejecting contention that "arbitration [is] an extraordinary procedure, and one especially disadvantageous for the beneficiary"].)

Quite simply, an arbitration provision in no way impacts the ability of any party to enforce the contract. Each has the same rights and remedies under the policy as they would if there were no arbitration agreement and the matter was allowed to proceed in court. The arbitration provision merely allows the matter to be expeditiously resolved in a manner more efficient for all concerned.

The bulk of the Court of Appeal opinion is devoted to its analysis of the second McCarran factor, i.e., whether the practice in question is an integral part of the policy relationship between the insurer and insured. Citing various cases, the Court essentially concludes that virtually any state law pertaining to the general relationship between insurer and insured is an "integral part of the policy relationship" for purposes of the McCarran-Ferguson Act. Yet, none of the cases the court cites even remotely supports the broad construction it urges, and review of the case law makes it clear that this Court has applied the McCarran Act *only* where the statute in question directly impacted the parties' entitlement to benefits under the insurance contract.

The centerpiece of the Court of Appeal opinion is *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 89 S. Ct. 564, 21 L. Ed. 2d 668 (1969), which is cited to support its assertion that virtually any law concerning insurers and insureds constitutes regulation of the business of insurance for purposes of the McCarran-Ferguson Act. Review of the decision belies the court's characterization. The broad language the court cites from the decision does nothing more than reaffirm the general rule – that state statutes that regulate the *policy* relationship between insurers and insureds, i.e., substantively affect the parties' rights to benefits under the insurance agreement, fall within the McCarran-Ferguson Act.

If anything, *National Securities* makes it clear not every statute that indirectly affects the relationship between insurer and insured is subject to the McCarran-Ferguson Act. Thus, this Court declined to apply the McCarran Act to an Arizona statute "relating to insurance

securities" because that statute did not address the relationship between the insurer and the policy holder. 393 U.S. at p. 462. However, it concluded that another provision of state law which gave the state Director of Insurance the power to evaluate an insurance company merger would fall within the McCarran Act, because part of the Director's task would be to determine whether the merger would "'substantially reduce the security of and service to be rendered to policyholders' [*sic*] before he gives his approval." 393 U.S. at p. 462. Thus, in *National Securities*, this Court again focused on the regulation of the substantive aspect of the insurer-insured relationship, i.e., the impact on the "security of and service to" be rendered to policyholders.

Nor does the *United States Department of Treasury v. Fabe*, *supra*, support the Court of Appeal's conclusion. In *Fabe*, the reason this Court found the state insolvency law concerned an integral part of the policy relationship between the insurer and insured was because it directly affected the substantive rights of the insured in that it promoted the goal of seeing that insureds were properly paid in accordance with the policy terms to the extent any funds were available to do so. 508 U.S. at p. 506, 113 S. Ct. at p. 2210.

Similarly, in *UNUM Life Ins. Co. of America v. Ward*, *supra*, 526 U.S. 358, the Court found that the California notice-prejudice rule fell within the McCarran Act, precisely because it affected whether or not an insurance company would have a defense to paying a claim under the policy. (See AOB 24, citing *UNUM*, 526 U.S. at p. 369, 374.) The Court of Appeal asserts that in *UNUM* the Court rejected the contention that a state statute had to concern substantive benefits under the policy in order to fall

within the McCarran Act. (See Appendix, pp. 32-33, citing *UNUM*, *supra*, 526 U.S. at p. 375 n.5.) However, this Court did nothing of the kind. Rather, the Court rejected the insurer's contention that only regulation of specific policy terms, and not administration of benefits under a policy, would fall within the McCarran-Ferguson Act. 526 U.S. at 375 n.5. But that, of course, is not what PacifiCare is contending here. This Court has never required a state statute to regulate a specific policy term, but it has *uniformly* applied the McCarran Act solely to state regulations that directly affect the contracting for, and determination of, benefits under a policy. Plainly, an arbitration provision has no impact on initiation of the insurer/insured relationship, or on the ability of one party or the other to receive benefits under the policy; rather, such provisions are neutral.

Moreover, none of the lower court decisions cited by the Court of Appeal support its conclusion. *Mutual Reinsurance Bureau v. Great Plains Mutual Ins. Co., Inc.*, 969 F.2d 931 (10th Cir. 1992), flatly misreads the applicable authorities and improperly concludes that the McCarran Act applies whenever a state regulation concerns the contractual relationship between an insurer and an insured without respect to whether it is "integral" to that relationship. In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S. Ct. 3002, 73 L. Ed. 2d 647, this Court rejected such a broad construction of the McCarran Act.[5]

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[5] Indeed, the linchpin of the *Mutual Reinsurance Bureau* opinion is the court's conclusion that an arbitration clause in an insurance agreement meets the first McCarran factor, i.e., affects the allocation of risk, because "a contract of insurance is evidence of an agreement to spread risk" and an arbitration provision places "limits on the

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Stephens v. American International Ins. Co., 66 F.3d 41 (1995), *Quackenbush v. Allstate Ins. Co.*, 121 F.3d 1372 (1997), *Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277 (10th Cir. 1998), and *Munich American Reinsurance Co. v. Crawford*, 141 F.3d 585 (5th Cir. 1998) – the latter two cases relegated to a footnote (Appendix, p. 33 n.19) – similarly provide no support for the court's position. The court cites them for the proposition that lower federal courts have held that state statutes barring arbitration of insurance agreements necessarily fall within the McCarran Act. Yet, the court ignores the fact that *Stephens*, *Quackenbush*, *Davister* and *Munich* involved invalidation of arbitration provisions in cases subject to state insurance *insolvency proceedings*. Thus, in all of these cases, the courts relied on *Fabe*'s holding that state *insurance insolvency and liquidation laws* as a general matter constitute the regulation of the business of insurance. This is because in the end, such laws protect policy holders with respect to benefits under the policies by "assuring that an insolvent insurer will be liquidated in an orderly and predictable manner and the anti-arbitration provision is simply one piece of that mechanism." *Stephens*, 66 F.3d at p. 45; see also *Quackenbush*, 121 F.3d at 1381 ["if a California law prohibited arbitration of disputes involving an *insolvent* insurer, then that law would undoubtedly also be saved from preemption by the

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enforceability of an agreement to spread risk. . . . " 969 F.2d at 933. As previously noted, however, the first McCarran factor requires the regulation in question to affect the *allocation or transfer* of risk as between the insurer and insured and as even the Court of Appeal here recognized, arbitration provisions simply have no impact on allocation or transfer of risk. (Appendix, p. 32 ["It is true that section 1363.1 does not transfer risk"].)

FAA. . ."]; *Davister*, 152 F.3d at 1281; *Munich*, 141 F.3d at 591-593. Significantly, none of the cases suggest that independent of the presence of a state insolvency scheme, that regulation of arbitration would fall within the McCarran Act. To the contrary, as review of the decisions reveals, in each case it is the existence of the *insolvency mechanism* itself that constitutes the regulation of insurance under the McCarran Act.[6]

Plainly, Health and Safety Code section 1363.1 does not address a practice that is "integral" to the *policy* relationship between an insurer and an insured. At most, an arbitration provision merely affects the forum in which

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[6] By way of footnote, the Court of Appeal also cites *Standard Security Life Insurance Co. of New York v. West*, 267 F.3d 821 (8th Cir. 2001), where the Eighth Circuit held that a Missouri statute limiting arbitration provisions in insurance contracts was not preempted by the FAA because it fell within the McCarran-Ferguson Act. Yet *Standard Security* flatly misapplies controlling this Court's precedent. First, the chief basis of the *Standard Security* decision is that regulations concerning arbitration and insurance contracts necessarily fall within the first McCarran factor as affecting the allocation of risk, echoing the reasoning of *Mutual Reinsurance*, 969 F.2d 931, to the effect that since insurance contracts generally involve transfer of risk, any statute that affects enforcement necessarily affects allocation of risk. As previously noted, however, that reasoning has been expressly rejected by this Court and even the Court of Appeal here admits section 1363.1 in no way affects allocation of risk between the parties. *Standard Security* also erroneously concludes that statutes regulating arbitration provisions in insurance contracts regulate the "business of insurance" because they apply to the processing of disputed claims, and that this has "a substantial effect upon the insurer-insured relationship and the policy's interpretation and enforcement . . . ." 267 F.3d at 823. However, arbitration does not have an impact upon the insurer-insured relationship or a policy's interpretation – it is assumed that arbitration is a neutral forum and that the parties' substantive rights to benefits under the policy will not vary depending upon whether or not a case is arbitrated or proceeds to trial.

any claim for benefits will be adjudicated, with each party retaining all of its full rights to benefits under the agreement. Under the governing authority of this Court, such a law does not regulate the business of insurance, and thus is preempted by the FAA.

3. Section 1363.1 is not limited to insurance entities and even if it were, this factor is insignificant in light of its failure to meet the other McCarran factors.

The final McCarran-Ferguson factor is whether or not the regulation in question pertains solely to insurance entities. As noted in Section I, *supra*, health care service plans are not insurance. However, even assuming that a health care service plan constitutes insurance and section 1363.1 is found to be directed solely to such "insurers," this would not be dispositive of the inquiry for purposes of the McCarran-Ferguson Act. As this Court has repeatedly noted, statutes may be specifically directed to regulating the incidental activities of insurance companies, yet not be deemed to be regulating the "business of insurance." Thus, in *Pireno*, the practice in question clearly involved the business activity of an insurance company in making claims determinations – the use of peer review committees to evaluate submitted charges for services. Yet, nonetheless, because the regulation did not impact the allocation of risk or alter anything that was an integral part of the policy between insurer and insured, it was deemed not to be the business of insurance within the McCarran Act. Similarly here, too, as noted above, the arbitration provision in no way impacts the allocation of risk nor constitutes an integral part of the policy relationship. Hence,

section 1363.1 is not a state statute regulating the business of insurance and therefore is preempted by the FAA.

CONCLUSION

For the foregoing reasons, defendants respectfully submit that the Petition for Certiorari should be granted.

Respectfully submitted,

KONOWIECKI & RANK
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TIMOTHY T. COATES

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE
STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION THREE

LISA ELLEN SMITH, Plaintiff and Respondent, v. PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC., et al., Defendants and Appellants.	B142321 (Los Angeles County Super. Ct. No. BC219095)
GEORGE RIVERA, PETITIONER, v. SUPERIOR COURT OF CALIFORNIA FOR THE COUNTY OF LOS ANGELES, RESPONDENT, PACIFICARE OF CALIFORNIA, Real Party in Interest.	B145004 (Los Angeles County Super. Ct. No. BC229915)

APPEAL from an order of the Superior Court of Los Angeles County. Frances Rothschild, Judge; David Doi, Judge. Affirmed and remanded with directions.

Petition for Writ of Mandate. Brett C. Klein, Judge. Petition Granted.

App. 2

(Filed Oct. 25, 2001)

Konowiecki & Rank and Gary S. Pancer; Greines, Martin, Stein & Richland and Timothy T. Coates for PacifiCare Behavioral Health of California, Inc., PacifiCare of California, PacifiCare Health Systems Foundation and PacifiCare Health systems, Inc, Defendants and Appellants and PacifiCare of California, PacifiCare Health Systems Foundation and PacifiCare Health Systems, Inc.

Shernoff, Bidart & Darras, Michael J. Bidart and Jeffrey Isaac Ehrlich for Lisa Ellen Smith, Plaintiff and Respondent and George Rivera, Petitioner.

These consolidated proceedings involve the question whether a health care service plan may enforce an arbitration clause contained in the plan and in related subscriber agreements which does not comply with the statutory disclosure requirements applicable to such clauses. In case No. B145004, the petitioner, George Rivera, seeks a writ of mandate vacating a trial court order granting the motion of the real party in interest, PacifiCare of California (PacifiCare), to compel arbitration in accordance with the plan's arbitration clause. In case No. B142321, PacifiCare has appealed the order of the trial court denying PacifiCare's motion to compel arbitration pursuant to the same clause. The respondent, Linda Smith, makes the identical arguments in support of the trial court's order in her case as does Rivera in his.[1]

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[1] We have consolidated these cases on our own motion. While they involve different plaintiffs in the underlying actions, the defendant,

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As a part of its regulation of health care service plans, California imposes certain disclosure requirements as a predicate to the enforcement of arbitration clauses contained in plan subscriber agreements. Health and Safety Code section 1363.1 (section 1363.1) (see fn. 15, *post*) provides that a binding arbitration clause in a health care service plan must incorporate various disclosures, including a clear statement of "whether the subscriber or enrollee is waiving his or her right to a jury trial. . . . " The waiver language must be substantially in the wording provided in Code of Civil Procedure section 1295, subdivision (a),[2] and must appear immediately before the signature line for the individual enrolling in the plan. (§ 1363.1, subds. (c), (d).)

These cases present the question whether the failure to comply with the mandate of section 1363.1 will invalidate the right of PacifiCare to enforce the arbitration clause in its subscriber agreements with Smith and Rivera. Although it has been held that the provisions of the Federal Arbitration Act (9 U.S.C. § 1, et seq.) (hereafter, FAA) preempt section 1363.1 and prevent its

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PacifiCare (and related entities) is the same in both cases, the relevant factual issues are very similar and the legal issues are identical. Moreover, counsel are the same and they make identical arguments in both cases. Thus, it is appropriate that the cases be decided in a single opinion.

[2] Code of Civil Procedure, section 1295, subdivision (a), specifies the language which must be utilized in an arbitration clause inserted in any contract for medical services. It provides that the clause must state that any dispute as to professional negligence will be determined by arbitration "and not by a lawsuit or resort to court process," and that the parties "are giving up their constitutional right to have any such dispute decided in a court of law before a jury. . . . "

enforcement, what has not yet been decided by a California court, is whether the McCarran-Ferguson Act (15 U.S.C., § 1011, et seq.) (hereafter, McCarran-Ferguson) overrides the FAA and precludes its preemptive impact on section 1363.1. This is a significant issue, the resolution of which will turn on whether section 1363.1 constitutes a regulation of the business of insurance within the meaning of McCarran-Ferguson.

After a careful examination of the relevant authorities, we are persuaded that section 1363.1 does constitute such regulation and therefore, the FAA cannot preempt section 1363.1 and the latter's provisions must be enforced. As a result, we will grant the requested writ relief in case No. B145004 and will affirm the trial court's order in case No. B142321.

FACTUAL AND PROCEDURAL BACKGROUND[3]

As we summarize below, Rivera and Smith have each filed an action against PacifiCare seeking damages for injuries sustained as the result of PacifiCare's alleged failure to provide promised plan benefits, including the failure to timely authorize or extend needed treatment by health providers. In each case, PacifiCare responded to the complaints with a motion to compel arbitration.

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[3] There is no dispute between the parties as to the relevant facts. We recite only those facts necessary to describe the context for the legal issue that we resolve.

1. *Rivera Background Facts (case No. B145004)*

In May of 1999, Rivera was an employee of the County of Los Angeles (County). County had previously entered into a contract with PacifiCare to provide health insurance for its employees (referred to in the PacifiCare documents as "members"). The agreement between PacifiCare and County consists of a "Business Agreement" (signed by the County)[4] and three forms of "subscriber agreements" depending on the coverage option selected by the member. All forms of the subscriber agreements contained an arbitration clause to which each member became bound upon his or her execution of the enrollment form.[5] In

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[4] The "Business Agreement" was actually entered into not only by PacifiCare, but also a related company, PacifiCare Life and Health of California. Our reference to PacifiCare shall be deemed to include both companies. The "Business Agreement" expressly provides that both companies are to "act in the capacity of the *County's insurer*" (italics added) with respect to all other services and supplies provided under the Group Benefits Agreements and under the Business Agreement.

[5] At paragraph 15.02 of the Subscriber Agreement the following provision is set out in capital letters and in bold type:

"15.02 *ARBITRATION.* PACIFICARE USES BINDING ARBITRATION TO RESOLVE ANY AND ALL DISPUTES BETWEEN PACIFICARE AND GROUP OR MEMBER, INCLUDING, BUT NOT LIMITED TO, ALLEGATIONS AGAINST PACIFICARE OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE PACIFICARE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED) AND OTHER DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PACIFICARE HEALTH PLAN. PACIFICARE, GROUP AND MEMBER EACH UNDERSTAND AND EXPRESSLY AGREE THAT BY ENTERING INTO THE PACIFICARE SUBSCRIBER AGREEMENT OR ENROLLING IN THE PACIFICARE HEALTH PLAN AND AGREEING TO BE BOUND BY THE PACIFICARE SUBSCRIBER AGREEMENT, PACIFICARE, GROUP AND

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addition, the evidence of coverage booklet (31 pages), provided to each member following enrollment, contained a further reference to the commitment to arbitrate any dispute.[6]

MEMBER ARE EACH VOLUNTARILY GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ALL SUCH DISPUTES DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. GROUP AND MEMBER FURTHER UNDERSTAND THAT ANY DISPUTES BETWEEN GROUP OR MEMBER AND A PACIFICARE CONTRACTING PROVIDER, INCLUDING, BUT NOT LIMITED TO, CLAIMS AGAINST A PACIFICARE CONTRACTING PROVIDER FOR MEDICAL MALPRACTICE, ARE NOT GOVERNED BY THE PACIFICARE SUBSCRIBER AGREEMENT. HOWEVER, PACIFICARE, GROUP AND MEMBER EACH EXPRESSLY AGREE THAT THE EXISTENCE OF ANY DISPUTES BETWEEN GROUP OR MEMBER AND A PACIFICARE CONTRACTING PROVIDER, INCLUDING, BUT NOT LIMITED TO, CLAIMS BY GROUP OR MEMBER AGAINST A PACIFICARE CONTRACTING PROVIDER FOR MEDICAL MALPRACTICE, SHALL IN NO WAY AFFECT THE OBLIGATION TO SUBMIT TO BINDING ARBITRATION ANY AND ALL DISPUTES BETWEEN GROUP OR MEMBER AND PACIFICARE."

[6] The reference to arbitration in the evidence of coverage documents provide that if a member is dissatisfied with the result of a redetermination made by PacifiCare under its "Appeals Process," then he or she may "within sixty (60) days, submit or request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before the American Arbitration Association." Following an extended discussion of the conduct of the mediation and arbitration process, the discussion of the "Appeals Process" concludes: **"MEMBERS UNDERSTAND THAT BY ENROLLING IN PACIFICARE, THEY AGREE TO GIVE UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION FOR RESOLVING DISPUTES WITH PACIFICARE."**

Following his enrollment in the PacifiCare plan, Rivera was diagnosed, on May 18, 1999, as suffering from a severe bacterial infection in his left foot. In the complaint he subsequently filed against PacifiCare, he alleged he was denied timely and proper treatment for this condition.[7] He had to wait three days for authorization to see a specialist. By the time of that appointment his condition had progressed to gangrene, and the surgeon recommended, on May 21, 1999, that he be admitted to the hospital that day, and that the small toe on his left foot be amputated within 24 to 48 hours, after antibiotics had controlled the infection. However, the medical group exercising its delegated authority to make utilization management decisions for respondent PacifiCare refused to authorize an admission to the hospital. When he was reexamined two days later, his infection had spread.

When Rivera's doctor learned, on May 23, 1999, that Rivera had not been admitted to the hospital as he had directed, he told Rivera to come to the hospital the next morning at 6:00 a.m. for admission and surgery on his foot. When Rivera arrived, however, he learned he was *not* on a list of patients whose admission had been authorized, and he was required to wait for hours. It turned out that Rivera's admission had not been authorized by a "hospitalist," a doctor employed by the participating medical group to coordinate hospital admissions and care. He was not seen by the hospitalist for another five hours. Because of the delay in admission, Rivera's surgery was not scheduled until the following day.

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[7] For purposes of this appeal, we accept these allegations as true.

After one of Rivera's doctors told Rivera's wife that he should have had the surgery three days earlier, she insisted that the surgery go forward. The surgeon arrived at 7:00 p.m. and was displeased at having been summoned; however, when he saw how far the infection in Rivera's foot had progressed he scheduled the surgery immediately. The operation began at midnight. The infection had spread during the time Rivera had been waiting for care, so that instead of having only his small toe amputated, it was necessary to remove two toes and a portion of the foot. A week after the surgery, Rivera's surgeon referred him for hyperbaric oxygen treatment, a therapeutic technique used to promote healing in necrotic tissue. The surgeon noted in the chart that Rivera's need was "urgent." Once again, however, PacifiCare delayed authorization for the prescribed treatment. Unfortunately, because of such delay, the gangrene progressed, and Rivera's surgeon recommended an amputation of the entire foot, above the ankle. When Rivera arrived at the hospital at 6:00 a.m. on the scheduled day, he was again kept waiting for hours – this time for an entire day – because of the need for the plan's hospitalist to admit him.

Not surprisingly, Rivera claims to have suffered substantial physical and emotional damage as a result of such conduct. Thereafter, he filed this action against PacifiCare on May 11, 2000.[8] In his first amended complaint (in which he is joined by his spouse, Rita

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[8] The PacifiCare entities named as defendants are PacifiCare of California, PacifiCare Health Systems Foundation, a California corporation and PacifiCare Health Systems, Inc., a Delaware corporation. As before, our use of the term "PacifiCare" is intended to include all of these entities.

Rivera), filed on June 14, 2000, he alleged 14 causes of action.[9]

PacifiCare's response was to file a motion to compel arbitration. This was heard by the trial court on August 15, 2000, and the motion was granted. Rivera filed a petition for a writ of mandate on October 13, 2000. Following some delay occasioned by the filing of additional briefing both in support of and in opposition to the petition, we issued an Order to Show Cause on March 15, 2001, and set the matter on calendar for hearing with the Smith appeal (B142321).

2. *Smith Background Facts (case No. B142321)*

Smith filed her complaint on October 26, 1999.[10] In that pleading, she alleged the factual basis for her claim

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[9] The 14 causes of action alleged by the Riveras are: (1) Breach of the Duty of Good Faith and Fair Dealing; (2) Conspiracy to Breach the Duty of Good Faith and Fair Dealing; (3) Breach of Contract; (4) Intentional Misrepresentation; (5) Professional Negligence; (6) Negligent Interference with a Contractual Relationship; (7) Intentional Interference with a Contractual Relationship; (8) Intentional Interference with a Patient/Physician Relationship; (9) Negligent Interference with a Patient/Physician relationship; (10) Breach of Fiduciary Duty; (11) Unfair Business Practices (Bus. & Prof. Code section 17200); (12) Intentional Infliction of Emotional Distress; (13) Negligent Infliction of Emotional Distress; and (14) Injunctive Relief for Violation of Civil Code section 1750, et seq. (the Consumer Legal remedies Act).

[10] In this pleading, the named defendants were PacifiCare Behavioral Health of California; PacifiCare of California; PacifiCare Health Systems Foundation, a California corporation; and PacifiCare Health Systems, Inc., a Delaware corporation. While one of these defendants is not a party to the Rivera action, we nonetheless intend that our reference to the term "PacifiCare" includes all of these entities.

against PacifiCare.[11] She is the stepdaughter and dependent of Thomas S. Battle, an administrator for the Rim of the World Unified School District in Lake Arrowhead. As an employee of the school district, Battle had the option of enrolling in the health plan offered through the Southern California Schools Employee Benefits Association. Under this plan, he received the bulk of his health care coverage from the Blue Cross Plus Preferred Provider Plan. Mental health benefits, however, were derived solely from a supplementing health plan sponsored by PacifiCare and marketed as PacifiCare Behavioral Health of California (PBHC). Smith, as Battle's dependent, was also covered under this mental health plan. This plan has language compelling arbitration to resolve any disputes that may arise. Such language is substantially the same as we have already described with respect to the Rivera action. (See fn. 5, *ante.*)[12]

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[11] In her complaint, Smith alleged ten separate causes of action: (1) Breach Duty of Good Faith and Fair Dealing; (2) Breach of Contract; (3) Intentional Interference with a Patient/Physician Relationship; (4) Negligent Interference with a Patient/Physician Relationship; (5) Breach of Fiduciary Duty; (6) Intentional Infliction of Emotional Distress; (7) Negligent infliction of Emotional Distress; (8) Professional Negligence; (9) Injunctive and Equitable Relief for Violation of Business & Professions Code section 17200; and (10) Injunctive Relief for Violation of Civil Code section 1750. As in the Rivera case, we accept Smith's allegations as true for purposes of this appeal.

[12] For example, the evidence of coverage for the PacifiCare mental health plan included the provision that if subscriber was dissatisfied with PacifiCare's internal "Appeals Procedure," then a request for binding arbitration to the American Arbitration Association could be submitted. After outlining the various aspects and contingencies of the arbitration process, the section on "Appeals Procedure" concluded with the following: "**BY ENTERING INTO THIS AGREEMENT, YOU**

(Continued on following page)

Smith became suicidal in 1998 due to an uncontrolled major psychiatric depressive disorder, bulimia nervosa, and anorexia nervosa. In response, PacifiCare terminated her physician-recommended inpatient treatment after only six days and refused to authorize or pay for additional inpatient care even when Smith's condition deteriorated further over the next two months. Such termination of the inpatient treatment appears to have been dictated by the terms of PBHC's plan. This plan offers to provide full coverage for inpatient stays up to thirty days. However, members are limited to one inpatient stay per year, and *stays of less than five days do not count toward this limitation.* By terminating Smith's inpatient treatment only six days after her admission, PacifiCare effectively ensured that, regardless of the state of Smith's mental health, the inpatient benefits Smith received could be kept to the minimum. PacifiCare's actions also ensured that Smith would receive no further inpatient benefits from PacifiCare for the balance of the year.

In filing her complaint, Smith, as did Rivera, sought substantial damages for the injuries she claimed to have sustained as the result of PacifiCare's alleged misconduct. PacifiCare responded to this complaint in the same manner as it did to the Rivera action. On December 15, 1999, it filed a petition to compel arbitration relying on the contractual provisions discussed above.

AND YOUR DEPENDENTS AGREE TO GIVE UP YOUR CONSTITUTIONAL RIGHTS TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY AND INSTEAD ACCEPT THE USE OF ARBITRATION FOR RESOLVING DISPUTES WITH PBHC."

On February 4, 2000, after reviewing the written arguments filed in support and opposition to PacifiCare's petition, the trial court heard the argument of counsel and denied the petition. This is an appealable order (Code of Civ. Proc., § 1294; *Fireman's Fund Ins. Companies v. Younesi* (1996) 48 Cal.App.4th 451, 456-457) and PacifiCare filed a timely appeal.

We thus have before us two different cases, involving substantially the same relevant factual circumstances, the same defendants, the same counsel on both sides and the same legal issue as to which two different trial judges reached the exact opposite conclusion.

CONTENTIONS OF THE PARTIES

Rivera and Smith (hereafter collectively referred to as plaintiffs) contend as follows:

1. PacifiCare is a health care service plan subject to the regulation of the Knox-Keene Health Care Service Plan Act of 1975 (Health & Saf. Code, § 1340 et seq.) (Knox-Keene Act), including section 1363.1;

2. The arbitration clauses of the PacifiCare agreements which PacifiCare sought to enforce by its petitions to compel arbitration do not comply with the mandatory disclosure requirements of section 1363.1 and therefore (absent the preemption issues raised herein) are unenforceable as a matter of law;

3. Health care service plans such as PacifiCare's are engaged in the business of insurance and section 1363.1 is a state law that regulates the business of insurance;

4. McCarran-Ferguson exempts a state law that regulates insurance from preemption by any federal statute, the effect of which would "impair, invalidate or supercede" such state law, *unless* the federal statute "*specifically relates to insurance.*"

5. The FAA would preempt and preclude the operation of section 1363.1, unless McCarran-Ferguson is applicable;

6. The FAA is a statute of general application and does *not* specifically relate to insurance; if the FAA were applied in either of these cases it would "impair, invalidate or supercede" the operation of section 1363.1;

7. Since the FAA cannot be applied without violating the mandate of McCarran-Ferguson, it cannot preempt section 1363.1; since the PacifiCare arbitration clauses do not comply with section 1363.1, PacifiCare is not entitled to enforce its demands for arbitration and its motions for such relief were improperly granted in the Rivera matter and properly denied in the Smith case.

Of the seven points made by the plaintiffs in the above summarized contentions, *PacifiCare concedes that five are not disputed.* The only points of disagreement which PacifiCare has are with contention number 3 and the conclusion expressed in contention number 7. It is PacifiCare's position that health care service plans are *not* engaged in the business of insurance and section 1363.1 is *not* a statute which regulates insurance. If PacifiCare is correct, then McCarran-Ferguson cannot be applied in this matter to preclude the preemptive effect of the FAA.

The problem presented by these consolidated matters is therefore both straightforward and focused; we must

decide two questions. First, are health-care service plans, such as PacifiCare's, engaged in the business of insurance? Second, is section 1363.1 a state law that regulates the business of insurance? We answer yes to both questions.

DISCUSSION

1. *Applicable General Principles and Undisputed Matters*

We begin our consideration of these questions by summarizing the factual matters and legal principles as to which there is no real dispute.

PacifiCare concedes that it is a licensed health care service plan.[13] Instead of purchasing individual or group health insurance, many persons and employers now contract with health maintenance organizations (HMOs) which, in turn, contract with health care providers (e.g., doctors, hospitals, medical groups, etc.) to provide actual health care services. (See e.g., *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284, 1289.) "Beginning in the late 1960's, insurers and others developed new models for health-care delivery, including HMOs. [Citation.] The defining feature of an HMO is receipt of a fixed fee for each patient enrolled under the terms of a contract to provide specified health care if needed. The HMO thus assumes the financial risk of

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[13] In a declaration filed in support of PacifiCare's petition to compel arbitration it is stated: "PacifiCare is licensed in accordance with the Knox-Keene Health Care Service Plan Act of 1975, as amended, Cal. Health & Safety Code Section 1340 *et seq. PacifiCare is a health care service plan that arranges for and facilitates the provision of health services for employer groups with which they contract.*" (Italics added.)

providing the benefits promised: if a participant never gets sick, the HMO keeps the money regardless, and if a participant becomes expensively ill, the HMO is responsible for the treatment agreed upon even if its cost exceeds the participant's premiums." (*Pegram v. Herdrich* (2000) 530 U.S. 211, 218-219, 147 L.Ed.2d 164, 120 S.Ct. 2143, 2149.)

In California, health care service plans (or HMOs) are licensed and regulated by the Department of Managed Care under the Knox-Keene Act.[14] As already noted, one of the provisions of that Act is section 1363.1.[15]

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[14] However, "[h]ealth care service plans under the Knox-Keene Act are generally subject to the jurisdiction of the Commissioner of Corporations (§ 1341), *not* the Insurance Commissioner. Thus, Insurance Code section 740, subdivision (g), exempts health care service plans from Department of Insurance jurisdiction (though the Commissioner of Corporations is to consult with the Insurance Commissioner to ensure consistency of regulations to the extent practicable under section 1342.5). Regulations concerning health care service plans are found in title 10 of the California Code of Regulations, section 1300.43 et seq." (*Williams v. California Physicians' Service* (1999) 72 Cal.App.4th 722, 729, fn. omitted.)

[15] Section 1363.1 provides: "Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets *all* of the following conditions:

"(a) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

"(b) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber *and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.*

(Continued on following page)

The arbitration provisions of the PacifiCare agreements with the plaintiffs did not comply with the disclosure requirements of section 1363.1. Essentially, the disclosures made in the agreements were not placed in the mandated juxtaposition with the enrollee's signature line and did not clearly disclose the scope of the arbitration as required by section 1363.1. PacifiCare does *not* dispute that there was a failure to comply with the requirements of section 1363.1. Instead, PacifiCare argues that such failure is irrelevant because section 1363.1 is preempted by the FAA and therefore does not apply.

The FAA applies to any "contract evidencing a transaction involving commerce" which contains an arbitration clause. (9 U.S.C. § 2.) Section 2 of the FAA provides that arbitration provisions shall be enforced, "save upon such grounds as exist at law or in equity for the revocation of any contract." (*Ibid.*) Thus, a state court may, without violating section 2, refuse to enforce an arbitration clause on the basis of "generally applicable contract defenses, such as fraud, duress, or unconscionability." (*Doctor's Associates, Inc. v. Casarotto* (1996) 517 U.S. 681, 687 [134 L.Ed.2d 902, 909, 116 S.Ct. 1652, 1656 [*Casarotto*].) Critically, however, a state court may not

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"(c) The disclosure shall *clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both*, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

"(d) In any contract or enrollment agreement for a health care service plan, *the disclosure required by this section shall be displayed* immediately before the signature line provided for the representative of the group contracting with a health care service plan and *immediately before the signature line provided for the individual enrolling in the health care service plan*." (Italics added.)

defeat an arbitration clause by applying state laws "applicable *only* to arbitration provisions." (*Ibid.*)

Thus, in *Casarotto*, the Supreme Court found that the FAA preempted a Montana law which had required an arbitration clause to be typed in underlined capital letters on the first page of any contract in order to be enforceable. (*Casarotto, supra*, 517 U.S. 681, 683.) Because the Montana law conditioned enforceability of the arbitration agreement "on compliance with a special notice requirement not applicable to contracts generally," it was preempted. (*Id.* at p. 687.)

The FAA would appear to apply to the PacifiCare agreements at issue here. First, the contract involves interstate commerce. In providing health services to enrollees, PacifiCare must, and does, contract with out-of-state entities. In addition, the agreement provides that PacifiCare will arrange for the provision of health services for enrollees, wherever they may travel, including out of state. These circumstances bring the PacifiCare agreements within the reach of the FAA. (See, e.g., *Summit Health, Ltd. v. Pinhas* (1991) 500 U.S. 322, 329 [114 L.Ed.2d 366, 375, 111 S.Ct. 1842, 1847] [Medicare provider that purchased out of state medicines and supplies engaged in interstate commerce for purposes of the Sherman Act]; *Toledo v. Kaiser Permanente Medical Group* (N.D.Cal. 1997) 987 F.Supp. 1174, 1180 [HMO contract concerned interstate commerce under FAA, where coverage provided for out-of-state injuries or illness and HMO obtained physicians and supplies from out of state].)

Moreover, section 1363.1 is obviously a regulatory provision applicable *only* to arbitration provisions, not to contracts generally. As already noted, this is precisely

what the FAA prohibits. Just as the Montana statute in *Casarotto* required that an arbitration provision contain particular language and be placed in a particular location in a contract, and hence was invalid under the FAA, so too, does section 1363.1 place restrictions on the manner in which an arbitration provision may be placed in a health care service contract.

Thus, in *Erickson v. Aetna Health Plans of California, Inc.* (1999) 71 Cal.App.4th 646, the court held that section 1363.1 was preempted by the FAA. Citing *Casarotto*, the *Erickson* court noted that section 1363.1 "imposes on arbitration clauses in health care plans 'a special notice requirement not applicable to contracts generally,'" and such "arbitration clauses must satisfy special requirements as to form and content which are not imposed on contracts generally." (*Id.* at p. 652.) As a result, section 1363.1 "'"takes its meaning precisely from the fact that a contract to arbitrate is at issue . . . ,"' and, consequently, conflicts with section 2 of the FAA." (*Ibid.*) Therefore, PacifiCare argues, section 1363.1 is preempted by the FAA.

Plaintiffs' response to this argument is that the FAA cannot preempt section 1363.1 because of the operation of McCarran-Ferguson.

2. *McCarran-Ferguson*

Congress enacted McCarran-Ferguson in 1945.[16] It sets forth a policy declaration that it is in the public interest that the primary regulation of the business of insurance be in the states, not in the national government. (15 U.S.C. § 1011.) It was passed in response to a United States Supreme Court decision (*United States v. South-Eastern Underwriters Assn.* (1944) 322 U.S. 533 [88 L.Ed. 1440, 64 S.Ct. 1162]) which held that the business of insurance was "commerce" within the meaning of the commerce clause and therefore the business of insurance was subject to all federal laws, including those relating to antitrust. (*Id.*, at p. 553.) This was a major change in the law. In 1869, the Supreme Court had held (*Paul v. Virginia* (1868) 75 U.S. (8 Wall.) 168, 183 [19 L.Ed. 357,

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[16] McCarran-Ferguson provides:

§ 1011. "Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."

§ 1012. "(a) *State Regulation.* The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

"(b) *Federal Regulation.* No Act of Congress shall be construed *to invalidate, impair, or supersede* any law *enacted by any State for the purpose of regulating the business of insurance*, or which imposes a fee or tax upon such business, *unless such Act specifically relates to the business of insurance.* Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], *shall be applicable to the business of insurance to the extent that such business is not regulated by State law.*" (Italics added.)

361]) that insurance was not "commerce" and therefore was not subject to federal commerce clause statutes.

The clear purpose of McCarran-Ferguson was to abrogate this change and to insure that the states would continue to enjoy broad authority in regulating the dealings between insurers and their policyholders. (*Cochran v. Paco, Inc.* (5th Cir. 1979) 606 F.2d 460, 462-463.) As the Supreme Court itself later explained, "The McCarran-Ferguson Act was passed in reaction to this Court's decision in *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944). Prior to that decision, it had been assumed, in the language of the leading case, that '[i]ssuing a policy of insurance is not a transaction of commerce.' *Paul v. Virginia*, [75 U.S.] (8 Wall.) 168, 183 (1869). Consequently, regulation of insurance transactions was thought to rest *exclusively* with the States. In *South-Eastern Underwriters*, this Court held that insurance transactions were subject to federal regulation under the Commerce Clause, and that the antitrust laws, in particular, were applicable to them. Congress reacted quickly. . . . The McCarran-Ferguson Act was the product of this concern. Its purpose was stated quite clearly in its first section; Congress declared that 'the continued regulation and taxation by the several States of the business of insurance is in the public interest.' 59 Stat. 33 (1945), 15 U.S.C. § 1011. . . . [¶] . . . In context, however, it is relatively clear what problems Congress was dealing with. Under the regime of *Paul v. Virginia*, *supra*, States had a free hand in *regulating the dealings between insurers and their policyholders*. Their *negotiations, and the contract which resulted*, were not considered commerce and were, therefore, *left to state regulation*. The *South-Eastern Underwriters* decision threatened the continued

supremacy of the States in this area. The McCarran-Ferguson Act was an attempt to turn back the clock, to assure that the *activities of insurance companies in dealing with their policyholders would remain subject to state regulation.*" (*SEC v. National Securities, Inc.* (1969) 393 U.S. 453, 458-459 [21 L.Ed.2d 668, 675-676, 89 S.Ct. 564, 567-568] (*National Securities*), italics added.)

Thus, there seems little question that Congress, by its passage of McCarran-Ferguson, "returned to the states the plenary power to regulate the business of insurance that they had enjoyed prior to the *South-Eastern Underwriters* decision. If Congress intended to invoke its Commerce Clause powers to occupy part of the field of insurance regulation, it would expressly say so." (*Cochran v. Paco Inc., supra*, 606 F.2d at p. 463, fn. omitted.)[17]

The mandate of McCarran-Ferguson appears to be both plain and clear. An act of Congress may not be construed to "invalidate, impair, or supercede" a state law enacted "*for the purpose of regulating the business of*

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[17] The legislative history of McCarran-Ferguson makes clear that it was Congress's intent that any law relating to interstate commerce that did not specifically relate to insurance would be subject to the provisions of McCarran-Ferguson. As one of the authors of the legislation, Senator Ferguson, put it during Senate debate, "If there is on the books of the United States a legislative act which relates to interstate commerce, if the act does not specifically relate to insurance, it would not apply at the present time. Having passed the bill now before the Senate, if Congress should tomorrow pass a law relating to interstate commerce, and should not specifically apply the law to the business of insurance, it would not be an implied repeal of this bill, and this bill would not be affected because the Congress had not . . . said that the new law specifically applied to insurance. (91 Cong. Rec. 481 (1945)." (*Cochran v. Paco, Inc., supra*, 606 F.2d at p. 463, fn. 7.)

insurance" unless the federal act "specifically relates to the business of insurance." (15 U.S.C., § 1012(b), italics added.) There is no dispute between the parties that the application of the FAA would have the effect of invalidating, impairing and superceding the operation of section 1363.1; indeed, it would absolutely preclude its use to regulate the wording and organization of PacifiCare's arbitration clauses. Similarly, there is no argument that the FAA is a statute of *general application* which does *not specifically relate* to the business of insurance. Thus, in order for us to conclude that McCarran-Ferguson does preclude the application of the FAA in these consolidated cases we need only address the integrally related questions as to whether health care service plans, such as PacifiCare, are engaged in the business of insurance and whether section 1363.1 is a statute enacted "for the purpose of regulating the business of insurance."

3. *Health Care Service Plans Are Engaged In The Business Of Insurance*

Statutes aimed at protecting or regulating the relationship between insurer and insured, directly or indirectly, are laws regulating the "business of insurance" within the meaning of that phrase as it is used in McCarran-Ferguson. (*National Securities, supra,* 393 U.S. 454, 459-460.) As the *National Securities* court emphasized, the focus of McCarran-Ferguson is upon the relationship between the insurer and its policyholders. "*The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were the core of the 'business of insurance.'* Undoubtedly, other activities of insurance companies relate so closely to their status as reliable insurers that

they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was – it was on the relationship between the insurance company and the policyholder." (*Id.* at p. 460, italics added.) "Cases interpreting the scope of the McCarran-Ferguson Act have identified three criteria relevant to determining whether a particular practice falls within that Act's reference to the 'business of insurance': '*first*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.' [Citations.]" (*Metropolitan Life Ins. Co. v. Massachusetts* (1985) 471 U.S. 724, 743 [85 L.Ed.2d 728, 742, 105 S.Ct. 2380, 2391]; see also *Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 48-49 [95 L.Ed.2d 39, 48, 107 S.Ct. 1549, 1553].)

In *Group Life & Health Ins. Co. v. Royal Drug Co.* (1979) 440 U.S. 205, 59 L.Ed.2d 261, 99 S.Ct. 1067 (*Royal Drug)* and *Union Labor Life Ins. Co.* v. *Pireno* (1982) 458 U.S. 119 73 L.Ed. 2d 647, 102 S.Ct. 3002 (*Pireno*) the Supreme Court first identified these criteria. These cases, however, involved the scope of the antitrust immunity which was granted by the second clause of 15 U.S.C. § 1012(b). (See fn. 16, *ante*.)

In *Royal Drug*, independent pharmacists brought an antitrust action against Blue Shield claiming that it was engaged in price-fixing of prescription drugs. The lawsuit attacked Blue Shield's use of "Pharmacy Agreements" between it and any pharmacy in the state that wanted to participate in its program. Under the agreements, a Blue Shield insured would pay the pharmacy $2.00 for a

prescription, and Blue Shield would reimburse the pharmacy for the actual cost of the drugs dispensed. The agreements essentially limited the participating pharmacy's profit on any prescription to $2.00. (*Royal Drug, supra,* 440 U.S. at 205, 209.)

The issue in *Royal Drug* was whether Blue Shield's conduct in entering into the Pharmacy Agreements was "the business of insurance" and therefore exempt from the antitrust laws. (*Royal Drug, supra,* 440 U.S. at p. 210.) The court held that the Pharmacy Agreements were not "the business of insurance" under the Act.

The court first noted that "insurance" inherently involves the spreading of risk between the insurer and its insureds, and that the Pharmacy Agreements did not spread risk because they did not involve any contract between the insurer and its insured. Rather, Blue Shield assumed the risk providing its insureds with prescription drugs for $2.00, and the Pharmacy Agreements were simply the means of providing the promised benefit at a low cost.

In the court's view, the Pharmacy Agreements were "indistinguishable from countless other business arrangements that may be made by insurance companies to keep their costs low." (*Royal Drug, supra,* 440 U.S. at p. 215.) Because of this, and because the agreements were between the insurer and entities outside of the insurance industry, the court held that the McCarran-Ferguson Act did not protect the practice.

In *Pireno*, a chiropractor challenged an insurer's use of a peer review panel to determine which claims for chiropractic care the insurer would pay. The insurer defended by claiming that the use of a peer review

committee was exempt from the antitrust laws as part of the business of insurance. (*Pireno, supra,* 458 U.S. 119, 122.) The court held that the use of peer review to determine whether to pay claims was not the "business of insurance" within the scope of the McCarran-Ferguson Act, and hence not exempt from the antitrust laws.

Pireno distilled from *Royal Drug* the "three criteria relevant in determining whether *a particular practice* is part of the 'business of insurance' exempted from the antitrust laws by [15 U.S.C. § 1012(b)]." (*Pireno, supra,* 458 U.S. 129, italics added.) "[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry. (*Ibid, italics omitted.*) In *Pireno*, however, the court cautioned that, "none of these criteria is necessarily determinative in itself." (*Pireno, supra,* 459 U.S. at p. 130.)

Applying the criteria to the peer review practice, the court determined that the practice did not spread risk, since the transfer of risk occurred when the policy was issued, and the peer review process was "logically and temporally unconnected to the transfer of risk." (*Pireno, supra,* 458 U.S. at p. 130.) The court also determined that peer review did not involve an integral part of the policy relationship between the insurer and its insured, nor was it limited to entities within the insurance industry, since the chiropractors performing the review were neither insureds nor within the insurance industry. (*Id.* at pp. 131-132.)

In *Department of Treasury v. Fabe* (1993) 508 U.S. 491 [124 L.Ed.2d 449, 113 S.Ct. 2202] (*Fabe*), however, the Supreme Court pointed out that both *Royal Drug* and *Pireno* were focused on the second clause of section 1012(b) which related to the narrow anti-trust issue rather than the broader language of the first clause. "The first clause commits laws 'enacted . . . for the *purpose of regulating* the business of insurance' to the States, while the second clause exempts only 'the business of insurance' itself *from the antitrust laws*. To equate laws 'enacted . . . for the purpose of regulating the business of insurance' with the 'business of insurance' itself, . . . would be to read words out of the statute." (*Id.* at p. 504, italics added.)

"The broad category of laws enacted 'for the purpose of regulating the business of insurance' consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance. [Citation.] This category necessarily encompasses more than just the 'business of insurance.' . . . [W]e believe that the actual performance of an insurance contract is an essential part of the 'business of insurance.' . . . [¶] . . . [T]he first clause of [15 U.S.C. § 1012(b)] was intended to further Congress' primary objective of granting the States broad regulatory authority over the business of insurance. The second clause accomplishes Congress' secondary goal, which was to carve out only a narrow exemption for 'the business of insurance' from the federal antitrust laws. [Citations.]" (*Fabe, supra,* 508 U.S. at p. 505.) Thus, "[t]here can be no doubt that the actual performance of an insurance contract falls within the 'business of insurance,' as we understood that phrase in *Pireno* and *Royal Drug*. To hold otherwise would be mere formalism. The Court's statement in *Pireno* that the 'transfer of risk from insured to

insurer is effected by means of the contract between the parties . . . and . . . is complete at the time that the contract is entered' [citation], presumes that the insurance contract in fact will be enforced. Without performance of the terms of the insurance policy, there is no risk transfer at all. Moreover, performance of an insurance contract also satisfies the remaining prongs of the *Pireno* test: It is central to the policy relationship between insurer and insured and is confined entirely to entities within the insurance industry." *Fabe, supra,* 508 U.S. at pp. 503-504.)[18]

As we pointed out earlier, HMOs or health care service plans, such as PacifiCare, are engaged in providing a service that is a substitute for what previously constituted health *insurance.* "The only distinction between an HMO . . . and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service [citation], but this is a distinction without a difference. [Citations.] In the end, HMOs function the same way as a traditional health insurer. The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs . . . are in the business of insurance." (*Washington Physicians Service Ass'n v. Gregoire* (9th Cir. 1998) 147 F.3d 1039, 1045-1046.) Other courts have also reached the conclusion that HMOs *are engaged in the business of insurance.* (*Kentucky Assoc. of*

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[18] Moreover, as we explain in the next section, the so-called *Pireno* factors are merely "considerations" to be weighed rather than essential criteria and, even if they were essential, they have been met in this case.

Health Plans, Inc. v. Nichols (6th Cir. 2000) 227 F.3d 352, 364; *Corporate Health Ins., Inc. v. Texas Dept. of Ins.* (5th Cir. 2000) 215 F.3d 526, 538; *Anderson v. Humana, Inc.* (7th Cir. 1994) 24 F.3d 889, 892; *Ocean State Physicians Health Plan v. Blue Cross* (1st Cir. 1989) 883 F.2d 1101, 1107-1108.) We believe the reasoning of these cases is sound and we have no trouble also concluding that PacifiCare, as a health care service plan (or HMO), is engaged in the business of insurance.

Significantly, the Legislature has reached the same conclusion in a very public way. It has *expressly* recognized that health care service plans in California *are engaged in the business of insurance within the meaning of the McCarran-Ferguson Act*. In 1999, it enacted the Managed Health Care Insurance Accountability Act of 1999, Statutes 1999, Chapter 536 (S.B. 21), partially codified at Civil Code § 3428. This statute provides a non-exclusive state-law-based remedy for injuries caused by the failure of managed care entities and health care service plans to provide medically appropriate treatment to their subscribers. In an uncodified section 2 to the Act, the Legislature stated: "SEC. 2.(a) The Legislature finds and declares as follows:

(1) Based on the fundamental nature of the relationships involved, a health care service plan and all other managed care entities regulated under the Health and Safety Code *are engaged in the business of insurance in this state as that term is defined for purposes of the McCarran-Ferguson Act* (15 U.S.C. Sec. 1011 and following). Nothing in this act shall be construed to impose the regulatory requirements of the Insurance Code on health care service plans regulated by the Health and Safety Code." (Italics added.)

The case on which PacifiCare relies (*Williams v. California Physicians Service, supra,* 72 Cal.App.4th 722) is not to the contrary. Indeed, it did not even address the issue before us. *Williams* simply held that a health care service plan regulated by the Knox-Keene Act was not necessarily the equivalent to an insurance company *for regulatory purposes*. *Williams* did not purport to address the issue confronting this court. *Rather, it simply recognized that the Legislature has elected to subject insurers and health care service plans to distinct regulatory regimes*. Insurers are regulated by the Insurance Code and the Insurance Commissioner. Health care service plans fall under the jurisdiction of the Department of Managed Care and the Knox-Keene Act. Hence, when the plaintiff in *Williams* sought to challenge the conduct of her health care service plan by invoking a provision of the Insurance Code, the court correctly held that the statute did not apply. Nothing in the reasoning or holding of *Williams* justifies PacifiCare's contention that somehow it is not engaged in the business of insurance.

This leaves us with the final and critical question. Does section 1363.1 constitute a regulation of that insurance business.

5. *Section 1363.1 Does Regulate The Business of Insurance*

The Supreme Court has recently made it clear that the so-called *Pireno* factors are merely "'*considerations* [to be] weighed' in determining whether a state law regulates insurance, [Citation], and that '[n]one of these criteria is necessarily determinative.'" (*UNUM Life Ins. Co. of America v. Ward* (1999) 526 U.S. 358, 373 [143 L.Ed.2d 462, 476, 119 S.Ct. 1389] [*Ward*].) Although it was

considering the issue in the context of the "savings clause" of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. §§ 1001, 1144(b)(2)(A)), the court's reasoning is obviously relevant here. The court repeated the comment made in an earlier decision where it noted that the *first question* to be addressed was whether the state law "'*fit a common-sense understanding of insurance* regulation'" and *then* the *Pireno* factors would be looked to as "*checking points* or '*guideposts, not separate essential elements . . . that must each be satisfied*' to save the State's law." (*Id.* at p. 374; italics added.)

In order to be within the common-sense definition of insurance regulation, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." (*Pilot Life Ins. Co. v. Dedeaux, supra,* 481 U.S. 41, 50.) Section 1363.1 falls squarely within the standard announced in *National Securities, supra,* 393 U.S. 453. It regulates the language and terms of the policies that HMOs can offer in California, by requiring HMOs that want to use mandatory arbitration to provide certain disclosures in the documents issued to its plan enrollees. Because it defines the language that HMOs must use in their plan documents, section 1363.1 operates directly on the relationship between the HMO and its insured/enrollee. The disclosure requirement is plainly an effort to protect insureds, hence the State has exercised its power to protect or regulate the relationship between the HMO and its members. This is exactly what *National Securities* says falls within the "core" of the business of insurance. (*Id.* at p. 460.)

Nothing in *Fabe* limits the test announced in *National Securities.* To the contrary, *Fabe* re-affirmed that test, holding that the Ohio law involved in that case fell within

scope of McCarran-Ferguson because it was "'aimed at protecting or regulating' the *performance of insurance contract.*" (*Fabe, supra,* 508 U.S. at p. 505.) The *Fabe* court rejected the Federal Government's contention that *Royal Drug* and *Pireno* had somehow supplanted the *National Securities* test, distinguishing those cases, and noting that they did not address the first clause of section 2(b) of McCarran-Ferguson (i.e., 15 U.S.C. § 1012(b)) relating to state laws *enacted for the purpose of regulating* the business of insurance, but rather focused on the second clause dealing with the narrower question of the anti-trust exemption. (*Id.* at pp. 502-504.)

Three federal appellate courts have concluded that state laws that restrict arbitration in the context of insurance are "state laws enacted for the purpose of regulating the business of insurance." (*Mutual Reinsurance Bureau v. Great Plains Mut.* (10th Cir. 1992) 969 F.2d 931, cert. denied 506 U.S. 1001 (1992); *Stephens v. American Intern. Ins. Co.* (2d Cir. 1995) 66 F.3d 41, 43-45; and *Quackenbush v. Allstate Ins. Co.* (9th Cir. 1997) 121 F.3d 1372, 1381.) In *Mutual Reinsurance,* (which pre-dated *Fabe*) the Tenth Circuit held that a Kansas law prohibiting arbitration clauses in insurance policies was not pre-empted by the Federal Arbitration Act, because it was a state law that regulated insurance. (*Mutual Reinsurance, supra,* 969 F.2d at p. 933.) The *Mutual Reinsurance* court relied primarily on *National Securities,* explaining that the Kansas statute regulated the relationship between the insured and the policyholder, and was therefore at the core of the business of insurance.

The Second Circuit reached the same conclusion in *Stephens,* holding that Kentucky's legislative scheme for liquidating failed insurance companies, which contained

an anti-arbitration provision, was protected by the McCarran-Ferguson Act. The court also relied on *National Securities* and *Fabe*, concluding that the statute in question was part of a state liquidation scheme that regulated the performance of insurance policies once an insurer (or reinsurer) is placed in liquidation. (*Stephens, supra,* 66 F.3d at p. 44.)

The Ninth Circuit's discussion of the issue in *Quackenbush* is admittedly dictum because the court explained that, unlike the Kentucky liquidation scheme, California's liquidation scheme lacked an anti-arbitration provision. (*Quackenbush, supra,* 121 F.3d at p. 1381.) But the court was clear that, "if a California law prohibited arbitration of disputes involving an insolvent insurer, then that law would undoubtedly also be saved [by McCarran-Ferguson] from preemption by the FAA." (*Ibid.*)

Even accepting the contention, however, that the issue should be decided by application of the *Pireno* factors, we believe that the facts and circumstances presented here demonstrate that those criteria, as recently characterized and applied by the Supreme Court in *Ward, supra,* 526 U.S. 358, are in fact sufficiently met. It is true that § 1363.1 does not transfer risk. Plaintiffs concede the point, but argue that the issue is irrelevant. *Ward* makes it clear that even if the *Pireno* test is applied, *not all three parts must be met.* PacifiCare contends that the second prong is also not met because § 1363.1 regulates arbitration provisions, which, PacifiCare argues, are not an integral part of the policy relationship between the insurer and the insured. PacifiCare contends that arbitration is really nothing more than a shift in forum, leaving a party's substantive rights under the policy unchanged. *Ward,* however, does not justify this argument. There, UNUM

argued that the notice-prejudice rule "regulates only the administration of insurance policies, not their substantive terms [and] it [therefore] cannot be an integral part of the policy relationship." (*Ward, supra*, 526 U.S. at p. 375, fn. 5.) The *Ward* court expressly rejected this argument. (*Ibid.*) Here, because § 1363.1 directly regulates the words that PacifiCare may use in its plan if it wants to include an enforceable arbitration clause, it regulates an integral part of the policy relationship. This relates directly to the *performance and enforcement* of the policy, a factor of critical importance under *Fabe*.[19]

PacifiCare finally contends that the third prong is not satisfied. It argues that because section 1363.1 affects health care service plans, and not insurance companies, the statute is not limited to insurance entities. We have already disposed of this contention. HMOs *are* engaged in the business of insurance when they offer health coverage

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[19] Citing *Fabe*, the court in *Standard Sec. Life Ins. Co. of New York v. West* (8th Cir. 2001) ___ F.3d___ held that a Missouri statute providing that arbitration provisions are "valid, enforceable and irrevocable," "except [in] *contracts of insurance* and contracts of adhesion" (italics added), was *not* preempted by the FAA because of the application of McCarran-Ferguson. Like here, there was no dispute that (1) the FAA did not specifically relate to the business of insurance and (2) its application would "invalidate, impair, or supersede" the Missouri statute. The question in *Standard Sec. Life* was whether the statute had been enacted to regulate the "business of insurance." (*Id.* at p. ___.) The court held that it was enacted for such purpose "because it applies to the processing of disputed claims. This processing, in turn, has a substantial effect upon the insurer-insured relationship and the policy's interpretation and enforcement, both of which are 'core' components of the business of insurance. [Citations.]" (*Id.* at p. ___.) Several other courts have reached the same result on similar reasoning. (See, e.g., *Davister Corp. v. United Republic Life Ins. Co.* (10th Cir. 1998) 152 F.3d 1277, 1279-1282; *Munich American Reinsurance Co. v. Crawford* (5th Cir. 1998) 141 F.3d 585, 590-594.)

to their members, and section 1363.1 clearly regulates this aspect of their endeavor. The fact that they are also involved in other activities that may not constitute the business of insurance is of no consequence to the issue before us.

Section 1363.1 is limited solely to HMOs, and parallels Insurance Code § 10123.19, which requires disability insurers (which includes health insurers) who wish to include arbitration clauses in their policies to make the same disclosures to their insureds. These provisions, which were simply different sections of the same legislation, evidence an effort by the Legislature to regulate the relationship between insureds and their insurers, *regardless of the type of coverage being provided.*

Ultimately, therefore, even if the *Pireno* test is to be applied, section 1363.1 meets that test as clarified and applied in *Ward*. Finally, as a simple matter of common sense, by conditioning the availability of arbitration in HMO subscriber contracts on the HMOs' compliance with the mandated disclosures, section 1363.1 regulates insurance.

CONCLUSION

For all of the foregoing reasons, we conclude that PacifiCare is engaged in the business of insurance and section 1363.1 clearly purports to regulate an important aspect of that business relating to the performance and enforcement of the policy. Thus, section 1363.1 does regulate the business of insurance within the meaning of McCarran-Ferguson. Therefore, the FAA, a federal statute of general application, which does not "specifically relate" to insurance, is foreclosed from application to prevent the

operation of section 1363.1. As a result, PacifiCare's arbitration provisions may not be enforced because of their failure to satisfy the specific and unambiguous disclosure requirements imposed by section 1363.1. The trial court erred in granting PacifiCare's petition to compel arbitration in the Rivera case and properly denied a similar petition in the Smith matter.

DISPOSITION

The order in Smith (B142321) is affirmed. In the Rivera writ proceeding (B145004), the order to show cause is discharged and a peremptory writ shall issue directing the trial court to vacate its order of August 15, 2000, granting PacifiCare's petition to compel arbitration and to enter a new and different order denying such petition. Upon remand, the trial court shall conduct such further proceedings as are appropriate in each case and are consistent with the views expressed herein. Both Smith and Rivera shall recover their costs incurred in these appellate proceedings.

CERTIFIED FOR PUBLICATION

CROSKEY, J.

We concur:

KLEIN, P.J.

ALDRICH, J.

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF LOS ANGELES

Date: 02/10/00

HONORABLE David Doi **JUDGE**

HONORABLE **JUDGE PRO TEM**

Karen Hollis **Deputy Sheriff**

DEPT. 73

Liza M Perez DEPUTY CLERK

ELECTRONIC
RECORDING MONITOR

None Present Reporter

8:30 a.m. BC219095

LISA ELLEN SMITH
VS
PACIFICARE BEHAVIORAL HEALTH
OF CALIFORN [sic]

Plaintiff Counsel NO APPEARANCE

Defendant Counsel NO APPEARANCE

NATURE OF PROCEEDINGS:

DEFENSE MOTION TO COMPEL ARBITRATION/ STAY PROCEEDINGS;

The matter having been taken under submission by the Court after hearing, the

Court now rules on the Petition of the Defendants to Compel Arbitration and Stay Superior Court Action as Follows:

The Defendants' Peition [sic] to Compel Arbitration and Stay Superior Court Action is denied. The Defendants are ordered to answer or otherwise plead to the Plaintiff's Complaint within 30 days after service of Notice of this Ruling.

Clerk shall give notice of this ruling.

A copy of this minute order is sent via United States Mail this date.

Clerk's Certificate of Mailing executed.

MINUTES ENTERED
02/10/00
COUNTY CLERK

Court of Appeal, Second Appellate District
Division Three – Nos.
B142321/B145004
S102718

IN THE SUPREME COURT OF CALIFORNIA

En Banc

LISA ELLEN SMITH, Plaintiff and Respondent,

v.

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA INC., Defendants and Appellants.

And consolidated case

[Filed Feb 20 2002]

Petitions for review DENIED.

The request for an order directing depublication of the opinion is denied.

/s/ GEORGE
Chief Justice

California Health & Safety Code § 1363.1. Binding arbitration included as contract term; required disclosures and conditions

Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

(a) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

(b) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.

(c) The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

(d) In any contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with a health care service plan and

immediately before the signature line provided for the individual enrolling in the health care service plan.

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9 U.S.C. § 1. "Maritime transactions" and "commerce" defined; exceptions to operation of title

"Maritime transactions", as herein defined, means charter parties, bills of lading of water carriers, agreements relating to wharfage, supplies furnished vessels or repairs to vessels, collisions, or any other matters in foreign commerce which, if the subject of controversy, would be embraced within admiralty jurisdiction; "commerce", as herein defined, means commerce among the several States or with foreign nations, or in any Territory of the United States or in the District of Columbia, or between any such Territory and another, or between any such Territory and any State or foreign nation, or between the District of Columbia and any State or Territory or foreign nation, but nothing herein contained shall apply to contracts of employment of seamen, railroad employees, or any other class of workers engaged in foreign or interstate commerce.

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9 U.S.C. § 2. Validity, irrevocability and enforcement of agreements to arbitrate

A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to

settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.

---

15 U.S.C. § 1012. Regulation by State law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known

as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

No. S _____
2d Civil No. B142321

IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA

LISA ELLEN SMITH,

Plaintiffs and Respondents,

vs.

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC., et al.,

Defendants and Appellants.

Appeal from the Superior Court of
Los Angeles County
Honorable Frances Rothschild, Judge
(Los Angeles County Superior Court
Case No. BC219095)

PETITION FOR REVIEW

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Foundation and PacifiCare Health Systems, Inc.

QUESTION PRESENTED

Is Health and Safety Code section 1363.1, which purports to regulate arbitration provisions in health care service plan agreements preempted by the Federal Arbitration Act (9 U.S.C. § 2) as the court held in *Erickson v. Aetna Health Plans of California, Inc.* (1999) 71 Cal.App.4th 646, or is it a law regulating the business of insurance under the McCarran-Ferguson Act (15 U.S.C. § 1011, et seq.) and thus saved from preemption?

* * *

Supreme Court, U.S.
FILED
JUN 24 2002
CLERK

No. 01-1716

IN THE

Supreme Court of the United States

PACIFICARE BEHAVORIAL HEALTH OF CALIFORNIA,
PACIFICARE OF CALIFORNIA, INC.,
PACIFICARE HEALTH SYSTEMS, INC.,

Petitioner,

v.

LISA ELLEN SMITH,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO
THE CALIFORNIA COURT OF APPEAL

BRIEF IN OPPOSITION OF RESPONDENT LISA ELLEN SMITH

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STATEMENT OF THE CASE

California statutes regulate arbitration clauses in health plans by requiring the plan documents to include certain disclosures. These disclosure requirements apply to plans issued by traditional indemnity insurers and to plans issued by health maintenance organizations (called health care service plans in California.)

Indemnity insurers in California are regulated by the Commissioner of Insurance and the Insurance Code, while health care service plans are regulated by the Director of Managed Health Care and the Health & Safety Code.

The bill requiring the arbitration disclosures in health plans (Stats. 1994, c. 653 (A.B. 3260) contained separate, largely identical sections dealing with insurers and health care service plans. The provision pertaining to insurers was codified as § 10123.19 of the Insurance Code. The provision pertaining to health care service plans was codified as § 1363.1 of the Health & Safety Code.

Petitioner Pacificare Behavioral Health of California is a health care service plan. It is undisputed that the health plan it sold to respondent Lisa Smith did not comply with the requirements of Health & Safety Code § 1363.1.

Smith filed an action against the plan and its related entities (collectively "Pacificare") in the Superior Court of California for tortious denial of plan benefits. The Pacificare defendants moved to compel arbitration, and Smith resisted the

petition based on Pacificare's failure to comply with § 1363.1. The trial court denied the petition to compel arbitration (App. 36) and Pacificare appealed.

REASONS WHY THE WRIT SHOULD BE DENIED

A. The Court's decision in *Rush Prudential HMO v. Moran* has settled that HMOs are engaged in the business of insurance

The first question presented in Pacificare's petition is "are health care service plans 'insurance' under the McCarran-Ferguson Act, 15 U.S.C. § 1012?" *Rush Prudential HMO v. Moran*, __ U.S.__, __ S.Ct. __, 2002 WL 1337696 (2002), squarely answers that question in the affirmative. *Moran* holds that an Illinois statute regulating HMOs qualifies as a law that regulates insurance under ERISA's saving clause.

While *Moran* is an ERISA decision, its reasoning is equally applicable to cases arising under the McCarran-Ferguson Act. "The ERISA saving clause . . . appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744, 105 S.Ct. 2380, 2391 (1985). *Moran* therefore fully answers the first question presented in the petition.

B. There is no need for this Court to clarify the standards it has articulated to determine whether a state law regulates insurance

Pacificare's fall-back position is that this Court should grant certiorari to "clarify" the standards used to determine whether a state law regulates insurance. But there is no ambiguity in the standards and Pacificare's petition does not suggest that any ambiguity exists.

The California appellate court carefully articulated and applied this Court's precedents. (App. 20-28.) Pacificare simply disagrees with the lower court's conclusions and asks this Court to correct what it sees as error. It is Smith's understanding that this Court is reluctant to grant certiorari simply to correct the mis-application of a properly stated rule of law. Sup. Ct. R. 10.

This case involved the interpretation the first clause of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which is highlighted below. The first clause confers on the states the right to regulate the business of insurance. The full text of section 2(b) says:

> ***No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance***, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance:

> Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Two decisions by this Court have specifically construed the first clause of section 2(b) of the Act — *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 459, 89 S.Ct. 564 (1969), and *United States Dept. of Treasury v. Fabe*, 508 U.S. 491, 499, 113 S.Ct. 2202 (1993). Both decision are analyzed extensively in decision below. (App. 21-27.) Both decisions turned on what state laws qualified under the Act as a "state law enacted for the purpose of regulating the business of insurance."

National Securities did not purport to define the outer contours of which state laws qualified for the Act's protection, but it explained that the "core" of the business of insurance involved "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement . . . ." 393 U.S. at 459, 460. Hence, laws regulating these aspects of relationship between the insurer and its insured fall within the Act's protection.

Fabe applied the *National Securities* test, and it also analyzed the state law in question using a three-factor test developed in decisions construing the second clause of section 2(b) the Act. That clause creates an exemption to the federal antitrust laws for conduct by private parties (typically insurers) when they are engaged in the "business of insurance." *See Group Life & Health* v. *Royal Drug Co.*, 440 U.S. 205, 99 S.Ct. 1067 (1979), and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 102 S.Ct. 3002 (1982). The three factors are whether (1) the practice spreads risk, (2) forms an integral part of the policy relationship between the insurer and the insured, and (3) is limited to entities within the insurance industry. *Id.* at 129.

The Court's ERISA precedents rely, in part, on a flexible application of this three-factor test to determine whether a state law "regulates insurance" and is therefore within the scope of the ERISA saving clause. *UNUM Life Ins. Co. of America v. Ward* 526 U.S. 358, 373, 119 S.Ct. 1380 (1999).

In the decision below the California Court of Appeal analyzed Health & Safety Code § 1363.1 under both the *National Securities* test and the three-factor test, and found that it passed muster under either approach. (App. 22-34.)

Since the court below applied both tests, as this Court did in *Fabe*, it is not clear what Pacificare would have this Court "clarify." Pacificare has not demonstrated any need for this Court to grant its petition, other than to reach a different outcome.

C. The court below correctly held that § 1363.1 was a state law that regulated insurance

Moran explains that under both ERISA and the McCarran-Ferguson Act state laws survive preemption if they regulate insurers with respect to their insurance practices. *Moran*, 2002 WL 1337696 at *7. *Moran* establishes that HMOs are "insurers." *Id.* at *10. The remaining question, then, is whether § 1363.1 regulates their insurance practices. The Court of Appeal correctly held that it does.

Section 1363.1 tells HMOs what language they must include in their plan documents – the enrollment form and the policy itself – if they wish to use binding arbitration. The statute's regulatory focus therefore falls squarely within what *National Securities* called the "core" of the business of insurance: the relationship between the insurer and its insured, the type of policy that can be issued, and its enforcement.

Application of the three-factor test leads to the same conclusion, as the Court of Appeal explained. While the California statute may not spread risk, it does regulate an integral part of the policy relationship between the insurer and its insured; indeed it regulates the very words that may permissibly be used in the policy. This satisfies the second factor.

The third factor is satisfied as well, because the statute regulates only entities within the insurance industry — HMOs.

Since, as in *Ward* and *Moran*, the statute satisfies two of the three factors, it satisfies the flexible McCarran-Ferguson Act test. *Moran*, 2002 WL 1337696 at *10, citing *Ward*, 526 U.S. at 373. The Court of Appeal was therefore correct in finding that the McCarran-Ferguson Act shielded § 1363.1 from preemption by the Federal Arbitration Act.

CONCLUSION

Since *Moran* resolves the first question raised in the petition, and the second question is simply a request that this Court correct what Pacificare perceives as a misapplication of the three-factor test, there is no compelling reason for the Court to grant the petition.

Respectfully submitted,

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